GROUP HEALTH INSURANCE

The City of Memphis is proud to offer you one of the best benefits health plans in the country. The City offers two health plans: the **City of Memphis Basic Plan** and the **City of Memphis Premier Plan.** Both plans, administered by Cigna Healthcare, offer benefits including 100% preventative/wellness care without co-pays and a prescription drug plan, administered by Caremark.

THE CITY OF MEMPHIS BASIC PLAN

The Basic plan consists of a specified network of healthcare providers that contract with the city to provide services at a reduced rate..

THE CITY OF MEMPHIS PREMIER PLAN

The Premier Plan consists of a managed network of primary care physicians and specialist who are co-pays based only within the network.

Who administers our plans?
Cigna HealthCare administers both Plans. You can learn more about Cigna calling them at **1-800-Cigna24 (1-800-244-6224)** or visiting them on the web at www.cigna.com

How does the Basic Plan work?
Within this plan, you can go to any physician within the network without a referral. Basic Plan members pay an annual deductible of $350 per person or $1050 per family and have access to all physician specialists in network without referral at 90% of covered charges after deductible or out of network at 70% of usual and custom charges after deductible.

How does the Premier plan work?
The Premier Plan offers the opportunity to choose a Primary Care Physician (PCP), which serves as a source of routine care and can be changed as needed. Members pay an annual deductible of $100 per person up to 3 members of the family, and then plan goes to co-pay base of $20 per office visit to their PCP and $40 per specialist visit, with or without a referral. When visiting a physician outside the network or inside the network without a referral, members pay a $400 deductible per person or a $1200 deductible per family and the plan pays 60% of usual and customary charges.

With both plans, employees have access to preventative/wellness care services for every covered family member. Emergency and urgent care services are covered worldwide 24 hours a day. In order to provide the best access to doctors and hospitals and ensure the City of Memphis is paying fair medical rates, the Cigna Healthcare Provider network is available for a wide listing of Physicians and services. The in-network hospitals are Methodist, St. Francis and The Regional Medical Center (The “Med).

The plans also provide access to responsive service, an interactive web site and various sources of help and information over the phone. Again, you can call **1.800.Cigna24 (1.800.244.6224)** or visit the web site at www.cigna.com

Starting January 1, 2012 there was an update to the medical plans:

- A tobacco **surcharge** will be added to your medical premium if you and/or your covered family members use tobacco products
- A spousal **surcharge** will be added to your medical premium if you have a covered spouse who has accessibility to other healthcare, but choose to use the City of Memphis Health Plan.
- Each surcharge amount will be **$25.00** per pay period per family.

- Each employee enrolled in the **medical** plan must complete and submit an affidavit, which will give you the opportunity to waive the surcharge fees for tobacco usage and/or spousal accessibility, if applicable.

PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR ADDITIONAL INFORMATION CONCERNING BOTH PLANS.

PRESCRIPTION DRUG BENEFITS

Caremark administers prescription drugs for both the City of Memphis Basic Plan and The City of Memphis Premier Plan. Within the prescription drug benefits, you have the option of purchasing generic, formulary or non-formulary + name drugs. You can make purchases through the mail, at retail, or online at www.rxrequest.com.

What is a generic drug?
Generic drugs are chemically equivalent to their brand name counterparts. Generic drugs offer substantial cost savings over brand name drugs. You pay the lowest co-pay when you select generic medications and you help to keep your healthcare costs and premiums from increasing.

What is formulary or preferred drug list?
A formulary or preferred drug list is a list of preferred brand name and generic drugs that can meet a participant's needs at a lower cost than other brand name drugs. There are drugs assigned to the formulary for each therapeutic drug class. The formulary list is updated regularly as new drugs come on the market. Updated lists are available in the benefits office, online at www.caremark.com or by calling 1-800-722-2001.

What is the deductible for drug benefits?
There is a deductible of $25 and a maximum family deductible of $75 for prescription drugs. The deductible year runs January 1-December 31st. Each member must meet his or her deductible before the plan will begin picking up the balance of drug costs after the member makes his or her co-payment.

What are the co-pays for prescription drugs?

	Retail Program * *For immediate drug needs or short-term medications. 30-day supply*	**Mail Service Program** *For maintenance or long-term medications. 90-day supply*
Generic	$10	$20
Formulary	$20	$40
Non-Formulary Brand Name	$40	$80

***Utilization Management will be implemented to address appropriateness of therapies/treatment.**

Who should I contact if I have questions about the prescription drug plan?
You may contact Caremark at 1-866-722-2001, Monday through Friday, 7am- 9pm (CST) or you can visit them online at www.caremark.com

ENROLLING IN A HEALTH PLAN

Who is eligible?
All full time city employees and their eligible dependents may apply.

What is meant by an eligible dependent?
Eligible dependents include lawful spouse and children up to the age of 26. The employee must sign an affidavit certifying that the child is not eligible for another health plan.

It is your responsibility to remove any over age, married, divorced spouse or otherwise ineligible dependent from your coverage. Failure to remove any ineligible dependents will result in you being responsible for any claims paid on any ineligible dependent.

What information must I submit to enroll in a health plan?

- If you are applying for Individual Health Coverage, please complete the enrollment forms attached to this Benefits Packet and submit it to the Benefits Office within **31 days** of your hire date. Your decision remains in effect until our annual open enrollment period, unless there is a change in family status.
- If you are applying for Family Health Coverage, please complete the enrollment form attached to this Benefits Packet and submit it to the Benefits Office within **31 days** of your hire date accompanied by the following documentation:
    - **Social Security numbers for all dependents.**
    - **If enrolling your spouse: a copy of your marriage license**
    - **If enrolling an eligible dependent child: a copy of the birth certificate for each child or proof of legal custody or guardianship**

  Your decision remains in effect until our annual open enrollment period, unless there is a change in family status.

What is a change in family status?
A change in family status includes: marriage, divorce, birth of a child (newborn children are covered at birth if added to the plan within **60 days of birth**), adoption, and change in spouse's job status. Ex-spouse's loss of job and children's loss of insurance from another source is not considered changes in family status.
If you have a change in family status you may apply for coverage **within 60 days** of the date of the change or during the next Open Enrollment period.

What is the waiting period for benefits?
Benefits become effective the first day of the month following **30 days** of continuous, full-time employment, or the first of the month following **30 days** after receipt of the coverage application in the City of Memphis Benefits Service Center, whichever is later.

How do I add or delete dependents?
Dependents may be added **within 60 days** of the date of birth or marriage. Proof of relationship is required (i.e. birth certificate, certified copy of marriage license). To delete a dependent you must provide proof of change in family status (i.e. divorce decree or the date a child was last a full-time student).
Any changes, additions, or deletions to all health plans must be presented in person to the City of Memphis, Benefits Service Center located in City Hall room 438.

What is a pre-existing condition?
A pre-existing condition is an injury or sickness, for which a person received treatment, incurs expenses or receives a diagnosis from a physician or for which the symptoms existed during the 90 days before the coverage effective date. Pre-existing conditions are covered with proof of creditable coverage prior to your effective date or once an employee has been in a health plan through the City of Memphis for a continuous twelve (12) month period.

Who may I contact if I have additional questions?

- For health provider information or claims information you should call **1-800-**

Cigna24 (1-800-244-6224) or visit the web site at www.cigna.com

- Eligibility questions should be referred to the Benefits Office at (901)636-6761.

What are the healthcare premiums per pay period for 2012?

	Single	Family
City of Memphis Basic *Per Pay Period*	$69.30	$147.12
City of Memphis Premier *Per Pay Period*	$75.19	$151.87

***Please see the HIPAA OPT-OUT Notice and return to the Benefits Office.**